IN THE CENTRAL CRIMINAL COURT

INQUESTS ARISING FROM THE DEATHS IN THE LONDON BRIDGE AND BOROUGH MARKET ATTACKS OF 3rd JUNE 2017

WRITTEN SUBMISSIONS ON BEHALF OF

THE METROPOLITAN POLICE SERVICE

REGULATION 28

I. INTRODUCTION

1. Following receipt of the documents drafted on behalf of the parents and partner of Xavier Thomas and the families of Christine Archibald, Sara Zelenak, James McMullan, Alexandre Pigeard, Sebastien Belanger and Kirsty Boden, the MPS submits the following response to assist the Chief Coroner as to whether he should make a report to prevent future deaths (RPFD), the areas the report should cover and the extent of any such report.

2. The MPS notes and endorses the submissions made by CTI at paragraphs 65 to 71 of their submissions on findings and determinations. Paragraphs 3 to 10 below are set out for completeness.

II. LAW AND PROCEDURE

3. Pursuant to paragraph 7 of Schedule 5 to the Coroners and Justice Act 2009 (the 2009 Act) the Chief Coroner is required to make a report where:

   (a) a senior coroner has been conducting an investigation under this Part into a person's death,
   (b) anything revealed by the investigation gives rise to a concern that circumstances creating a risk of other deaths will occur, or will continue to exist, in the future, and
   (c) in the coroner's opinion, action should be taken to prevent the occurrence or continuation of such circumstances, or to eliminate or reduce the risk of death created by such circumstances

   the coroner must report the matter to a person who the coroner believes may have power to take such action."

4. Under the 2009 Act, the Chief Coroner is required to make a report only if the criteria in paragraph 7 are met.

5. Before making a report, the Chief Coroner must find based on all of the available material that there is a concern that "*circumstances creating a risk of other deaths will occur, or will continue to exist*."

6. A report will only be required if, the Coroner is satisfied that preventative action is required to address that risk. It is therefore open to a Coroner to decide not to make a PFD report on the basis that, although the evidence has revealed the existence of a concern falling within paragraph 7(1)(b), the Coroner is not satisfied that action should be taken in order to address that concern. This will often be because the Coroner is satisfied that action has already been taken to address the concern or that he considers that the information available to him is insufficient to enable him to reach an adequately informed judgment that further action is required.

7. The Chief Coroner's Guidance No.5, at paragraph 5, identifies the need for PFD reports to be "*clear, focused, meaningful and, wherever possible, designed to have practical effect*."

8. The above is of obvious application in a case where substantial steps have already been taken to address areas of concern raised at the inquests. It is also of relevance in areas where concerns are raised which relate to matters of professional judgment which require specialist knowledge (for example matters relating to policy, tactics and specialist police operations).

9. It should also be noted that the report is ancillary to the inquest and should not radically expand scope nor should it be prescriptive as to what steps should be taken rather the report's purpose is to draw attention to risks or areas of concern (as reflected in the words of the Act.)

10. The Coroner must therefore determine whether the information available to him establishes that circumstances exist which create a risk that further deaths will occur and if so, whether specific action needs to be taken in order to address that risk.

III. THE APPROACH OF THE MPS TO TERRORIST ATTACKS

11. Counter Terrorism (CT) Policing is a collaboration of all police forces from across England and Wales. The National Counter Terrorism Policing Headquarters is hosted by the MPS. It takes the responsibilities for keeping London and the UK safe extremely seriously. The attacks of 2017 were both horrific and tragic. The MPS is determined to continue improving the means by which the people of the UK are protected from such evil acts. There is no room for complacency, however, the evidence heard by the Chief Coroner shows that the MPS and its partners have thwarted many attacks and saved lives. The evidence shows that multi-agency procedures such as Operation PLATO saved lives. It shows that the uplift in armed policing ensured that London was better protected than ever when terrorists struck on 03.06.19.

12. There have already been detailed reviews carried out following the 2017 attacks, most notably the Anderson review. The Chief Coroner will be aware of the recommendations from Lord Anderson which have been implemented or are in the process of being implemented. The recommendations are forecast to be completed on schedule, by the end of 2019.

13. Lord Anderson concluded in the Implementation stock-take that "*though it will never be possible to prevent every attack, the measures being taken will, in my opinion, strengthen the existing ability of MI5 and CTP to stop most of them*." It is important not to understate the level of scrutiny and the steps already taken as a result of the Anderson Review and the Operational Improvement Reviews which formed part of that process.

14. The MPS of course understands the desire of those who lost loved ones or the lawyers who represent them to seek to make recommendations across a wide range of areas. The test, however, is "*whether the coroner has found that systemic risks or failures have been highlighted by the material in the particular investigation"* see CTI submissions 70 (c).

15. There is no desire to appear defensive or to stifle some of the proposals made by the lawyers acting for the families, however, there is a danger in well intentioned theories causing unnecessary public concern and or recommending changes which are injurious to public safety.

16. The MPS response to the proposals are set out below.

THE PARTNER AND FAMILY OF XAVIER THOMAS

I. THE SEARCH FOR XAVIER

17. The MPS does not accept that the evidence suggests any systemic risks or failures relating to the Marine Support Unit (MSU). The search by the MSU and coastguard was thorough and painstaking. The evidence of each witness was that if Xavier was alive in the water then he would have been found.

18. The actions of the MSU crew must be viewed in the context of an ongoing marauding terrorist attack.

19. The partner and family of Xavier Thomas have raised the following concerns.

(i) Whether infra-red devices provided to MSU boats are "fit for purpose" and whether procedures for who uses these should be reviewed

20. It is stated at [6] of the submissions that as the evidence of PC Bultitude was that the equipment took time to warm up and was awkward to use it was not fit for purpose. This is not accepted. The time that it takes for the IR camera to "warm up" was no more than thirty seconds (Day 3 p 94).

21. The point PC Bultitude was making was that the equipment was *"very good at picking up heat sources in fairly sterile situations."* He went on to explain that the search for Xavier was dynamic. In addition to this PC Bultitude said that he did not think that infra-red equipment of any kind would have assisted as, *"on the night in question the conditions were very good, it was very clear and I didn't feel it added anything to the*

initial phase of our search." Other crew members were not tasked with using the infra-red equipment for the same reason. PC Bultitude has considerable experience of the Thames and of searches for people in it, he was in the best possible position to decide what form the search should take.

22. The conditions were good for a visual search and the area to be covered was comparatively large for the use of infra-red equipment. For one officer to dedicate his eyes to the monitor rather than the water was not the best use of the crew.

23. PC Bultitude rejected the suggestion that the equipment was *antiquated* he said that it was *current.* His evidence was also that the MPS is in the process of procurement for new vessels and is looking at the way in which infra-red cameras are used (Day 3 p97). The procurement of new MPU vessels is ongoing and is subject to a full tender process. New equipment will be sourced for these vessels which will include infra-red technology. This is likely to be in the form of handheld infra-red devices which will allow a more dynamic use of the technology. The tender process is underway and is likely to take another six months to complete. Once complete it will be around 12 months before new vessels begin to arrive. The programme is a complete fleet replacement which includes a command and control vessel, five hard patrol boats and three ribs. To the extent that concerns have been raised action has already been taken.

(ii) A review of procedures for information sharing during searches

24. The family of Xavier state that HM Coastguard were unaware that the MSU vessels had left the search after completing a number of hasty and structured searches of the relevant area. This is said to be a concern.

25. To leave the search was a dynamic decision made by the MSU crew based upon the situation as it appeared on the river. The boats were operating within scenes unprecedented on the river and banks of the Thames. It should be noted that the MSU assisted in the evacuation of a casualty with a significant neck injury which may well have saved life.

26. The evidence of PC Bultitude was that the police are a "*declared resource to the Coastguard. We are not a dedicated resource…we are able to detach from a search and rescue operation if a more pressing police matter occurs."* PC Bultitude did not break off from the search until he was satisfied that if there was anyone in the water then they would have been found (Day 3 p114). He was correct in this assumption according to the expert evidence of Mr Savage (Day 13 p116). There was good communication on the water by crew shouting to the other boats. Experience shows that this is the best method of communication.

27. There is a real danger in imposing strictures upon those who have decades of experience of saving lives on the river by lawyers who do not.

28. There is no jurisdiction to make such a recommendation.

(iii) Consideration should be given to minimum search times

29. It is not thought that this would apply to the MPS, however, it is submitted that this is not a sensible recommendation. It is very much appreciated that learning a search was called off would be distressing to the family, however this cannot be a proper basis to impose a minimum search time.

30. The Coastguard and MSU will stay on the water as long as it takes to find a casualty. There is no basis to say that this search was called off early or that searches in general are being called off early. It was clear from the evidence from the Coastguard witnesses that such a suggestion would be very strongly rejected by the volunteers who risk their own lives to save others.

II. BRIDGE SECURITY

31. This area does not relate to the MPS and will predominantly be addressed by others.

32. It is not accepted that the fact that HVM is described as temporary reveals a risk to life. The challenges presented by these bridges are unique and should not be underestimated.

33. Two specific matters appear to be addressed to the MPS. These are addressed below for completeness.

(i) Guidance should be issued to CTSAs on the scope of highway authorities to assess locations

34. The family of Xavier notes the Chief Coroner's ruling at [81] where the evidence of DACSO is cited who expressed concern about the lack of a clear legal duty on those responsible for sites vulnerable to terrorist attacks. It is clear that DACSO was here referring to the lack of clear legal duty upon *private bodies* [Day 28 p21 to 22] this is therefore not relevant to any suggestion that there is insufficient guidance from the MPS to CTSAs as to the "*scope of highway authorities to assess locations.*"

35. The Chief Coroner will also note the evidence of Siwan Hayward of TfL who stated that more recently TfL have requested assistance from the MPS as to protective security measures for open spaces on highways and that this has been forthcoming and *very helpful* [Day 31 p91]. To the extent therefore that there was a perceived problem this has been resolved so far as the MPS is concerned.

(ii) Advice / training needs to be provided to CTSAs to ensure that they are aware of the full range of rapid response options to combat hostile vehicle attacks are known (sic)

36. It is clear from paragraph [15] which precedes this suggested recommendation that this is addressed towards COLP and not the MPS.

37. For completeness, however, the MPS can inform that Chief Coroner that all MPS CTSAs receive full training on HVM in all of its forms.

38. It should be noted that the deployment of temporary measures is a specialist capability now provided on request by the National Vehicle Threat Mitigation Unit to

all CTSAs. All MPS CTSAs and Security Co-ordinators are fully trained and receive comprehensive guidance in relation to the availability of this resource and its capabilities.

III. THE INVESTIGATION INTO KHURAM BUTT

39. The Chief Coroner found that the investigation into Butt was generally thorough and rigorous and that following an exhaustive inquiry into the evidence, no opportunities were missed by MI5 or SO15 which could realistically have saved the lives of those who died. Whilst this is not determinative of the matter, the recommendations must be viewed against that background.

(i) Anti-terror hotline (ATHL)

40. The family of Xavier Thomas understandably raise the fact that the call by Usman Darr to the ATHL was not passed to the SO15 investigative team or MI5.

41. Recommendations are made at [18 a-c] of their submissions as to a review of procedures, a central repository for information relevant to SOIs accessible by both agencies and the co-location of investigative teams.

42. Enhanced collaboration between MI5 and CT policing is a matter which has been debated and addressed over many years. The Anderson Review made recommendations in this regard which have been or are in the process of being implemented by the end of the year.

43. MI5 and CT police at present work closer together than they ever have before. The two organisations, however, perform different functions and there should be no attempt to combine them. SO15 is the close investigative partner of MI5, but as M said [Day 20 page 41] MI5 disseminate intelligence where it is assessed to be significant but *if they phoned me every day with every intelligence update, we would be overwhelmed*. It would be wrong to cut across the detailed work that has been done as a result of existing reviews into the 2017 attacks which include (according to the Lord Anderson Implementation Stock-take):

"an intensification of partnerships across the UK Intelligence Community [UKIC] and between MI5 and CTP, coupled with the wider sharing of intelligence with neighbourhood policing, local authorities and others".

44. The Chief Coroner will also be aware that there is an existing plan to co-locate London based elements of counter terrorism policing and MI5 by 2023.

45. The hotline call was passed to the ALM desk in SO15 but the failure to also pass the hotline call onto the investigative team exposed a process and supervision failing and was something M said had since been tightened up (Day 19 p 74). A learning point in relation to the call handling was identified by Lord Anderson and this has been implemented. Intelligence handling systems have been reviewed, and new processes are in place to ensure intelligence is recorded and disseminated appropriately. ATH technology has been upgraded including an automated answering system and messaging facility. SO15 has placed an extra level of supervision into the process of

intelligence handling from the hotline which will ensure that in the event that a human and supervision error occurs again this will be picked up by the extra supervisory check and the intelligence will then be passed on to the appropriate team. It would be wrong to make sweeping recommendations based on this small error where the identified matters are already well in hand on both a micro and macro level.

(ii) PLA assessments

46. These do not relate to the MPS, they are a MI5 tool.

(iii) Review of the threat apparent from mindset material

47. The family of Xavier Thomas notes that the material on Butt's devices is shocking to a lay-person. This is doubtless true. It is noted that the evidence from highly experienced MI5 and SO15 operatives is that such material is routinely encountered on the devices of those with an extremist mindset. The MPS fully understands why this would be shocking to right thinking people. There is no evidence to suggest, however, that the current approach is flawed. This is an area, in particular, where experience is fundamental in conducting a rational assessment of extremist material.

(iv) Increase in resources

48. Most publicly funded bodies would desire greater resources. The MPS position remains as set out at [73] of the submissions on findings and conclusions, that it was not that reasonable steps were not taken because of resource limitations. Even the best resourced state must prioritise valuable and finite resources.

(v) Campaign to raise awareness of the ATHL

49. The evidence has not revealed a lack of awareness of the hotline, quite the opposite. The motivations of those who call and what they will report is a complex question. CT Policing devotes considerable resources to publicising this facility. There is no basis to say that the current publicity level has exposed a systemic risk or failing. The Chief Coroner is not in a position to make such a recommendation.

50. The remaining matters at paragraphs 22 to 23 do not concern the MPS.

SUBMISSIONS FROM THE SIX FAMILIES

51. These are divided into three areas which are addressed below:

I. <u>PREVENTION</u>

(i) Various matters relating to SSHD and crowded places, highway authorities and transport networks

52. These does not relate to the MPS.

(ii) Police forces etc to review and enhance their capability to install HVM with reasonable speed where a threat is identified

53. If such a recommendation is made (and it is doubtful whether one is justified) it should not be directed at the MPS. Matters specific to PC Hone relate to COLP. The evidence was that once the threat to bridges was identified, HVM was installed extremely quickly (within seven days) for the reasons identified by DACSO.

54. The National Vehicle Threat Mitigation Unit (NVTU) now manages the National Barrier Asset and works with the HVM industry to raise awareness of threats and with event organisers and public bodies on HVM effectiveness. The NVTMU has a 24/7 response capability to begin the deployment of the NBA when required by police forces in the event of an emergency or where a threat has been identified. In the last 18 months there have been some innovative HVM designs and new companies providing modular / temporary HVM to the UK. The NVTMU works with these companies to protect the UK when HVM is required. The MPS would not wish to give operational details for obvious reasons, however, HVM can be deployed extremely quickly both within and outside working hours. Deployment response exercises are carried out to test this capability and the rapid response which is required.

(iii) Job checks on significant sites e.g. TfL, airports or rail network

55. This is not a matter that relates to the MPS.

(iv) SS and BVRLA to introduce terror attack vehicle hire checks to include real time exchange of information with law enforcement agencies and the security service

56. This is not a matter that relates to the MPS.

(v) HMG and "police forces" should assess whether current levels of police firearms officers are appropriate especially in London

57. This is not an appropriate recommendation for a report on the prevention of future deaths.

58. The citation of a Police Federation survey at DC8302 shows the danger of relying upon press reporting. It is correct that 57% of officers surveyed said that they would carry a gun if required to do so but the article does not reveal that only 26% said that the police should be routinely armed. The article correctly states that a significant minority of officers would resign if required to carry a gun. If it is being suggested that all MPS officers support routine arming then this poll does not establish such a proposition.

59. The submissions from counsel to the families amount to no more than speculation as to the effect that arming police officers with handguns might have upon terrorists acting with murderous intent who expect to die in the attack. The description of British Police Officers as *antiquated and unrealistic* is unfortunate (however phrased) in the context of the evidence which the Chief Coroner heard over the course of the inquests.

60. In order for the Chief Coroner to make such a recommendation he would need to have a rational basis to support a contention that (i) there is a lack of armed police officers in London; (ii) this amounts to a systemic risk or failure; and (iii) that a recommendation for routine arming on some level is necessary to prevent future deaths. That was not the evidence at these inquests.

61. It is for the Chief Officers of individual police forces to determine the number of authorised firearms officers in their areas based on a thorough assessment of threat and risk. The Government has provided £144 million over a five year period, to support a national uplift to armed policing capability and capacity, in order to respond more quickly and effectively to terrorist attacks. This means that the number of armed police will increase by approximately 1000. For security reasons, we cannot disclose the breakdown of the uplift by force. The number of armed response vehicles has more than doubled in London.

62. In London the 24/7 response time for Counter Terrorism Firearms Officers has been significantly reduced and the numbers of ARVs able to respond to a no notice terrorist attack have increased. It is this specialist resource that the public will rely upon in the event of a MTA.

63. On the night, ARVs arrived rapidly and they were able to neutralise the threat. Even if the Chief Coroner was satisfied of the above matters; to contemplate a governmental review (which in reality would require primary legislation) and fundamentally alter the nature of policing in England and Wales would radically expand the scope of the inquests. This would not be a practical or achievable recommendation.

64. As set out above this is not an appropriate topic for a prevention of future deaths report and the evidence does not support the contention advanced by the families. As the families note matters such as this are already being appropriately considered by the NPCC.

II. <u>INVESTIGATION INTO KHURAM BUTT</u>

(i) Suspension of the investigation / de-prioritisation / PLA assessment

65. These are not matters that relate to the MPS.

(ii) Review and challenge assumptions about mindset material

66. The submissions at paragraph [47] above are repeated.

67. It is not accepted that there was an *alarming* difference between the assessment of the material by MI5. It remains the case that this material is routinely found on devices belonging to terror suspects.

68. It is not understood what recommendation could be made to practical effect in this regard in any event.

(iii) Investigations should seek to identify the principal locations in which targets spend time

69. It is a fact that despite coverage of Butt his links to the Ad-Deen Primary School were not revealed. The proposed recommendation is premised upon the basis that this was due to a lack of interest or effort on the part of MI5. This is not accepted. Extensive efforts were made to identify the school. This included focused surveillance on Butt for an unspecified number of days including weekdays but the team(s) were not led to the school (Day 24 p133 – 134). SO15 followed the intelligence received from MI5 but this did not lead to the identification of the Ad-Deen School.

70. A recommendation from the Chief Coroner would have no practical effect. Investigations do seek to identify the principal locations in which targets spend time where appropriate and this was the intention in the instant case. They will not always succeed which is a different matter.

(iv) MI5 should analyse how the significance of UFC came to be missed

71. Whilst a matter for MI5, it is plain that this has been analysed and at the highest level by MI5, SO15, Lord Anderson, Parliament and the Chief Coroner to name but a few. A recommendation in these terms would have no practical effect.

72. The description of the gym at [80] is not supported by the evidence.

(v) MI5 and SO15 should explore ways of working more closely on investigations

73. The submissions at paragraphs [42 to 44] above are repeated. The working relationship is not one at "arm's length."

74. Such a recommendation would be otiose in the context of two bodies who are already committed to co-location of London resources by 2023.

(vi) Systems should be in place to ensure that contact from the public is correctly sent to MI5 and CT investigators

75. The submissions at paragraphs [40 to 45] above are repeated. The error that was made in relation to Usman Darr's call has already been addressed and the systems tightened.

(vii) Security service alerts re Schengen

76. This is not a matter that relates to the MPS.

(viii) Systems should be introduced to ensure maximum information is extracted from callers reporting on friends or families

77. It is not accepted that M (or L) were *dismissive* of the value of reports from members of the public. Such calls have to be appropriately assessed. There are valid reasons to treat intelligence from family members with care (as ultimately confirmed by the conduct of Usman Darr, revealed after he gave evidence).

78. The suggestion of "scripted follow up calls" for ATHL operators is not a matter upon which the Chief Coroner could or should make a recommendation. To require all operators to ask the questions which might *in this case* have yielded further information is not a serious proposition. Such a script would need to be extended indefinitely to cover situations other than those in these inquests.

79. The evidence of Usman Darr is rather selectively summarised. When first questioned he said that not only did he not expect a response or follow-up call from the authorities but that he did not want to be contacted (Day 21 p234 –235). He also said that after contacting the ATHL he distanced himself from Butt and had no further information to give (Day 21 p235). Finally, an error made on occasions during the inquest has again been repeated in the written submissions on behalf of the families, there was no evidence that Butt taught people how to fight in the gym, with the obvious inference that is intended, he taught boys to box, a very different and wholly unsensational pastime.

(ix) Section 38B Terrorism Act 2000

80. This does not relate to the MPS.

III. <u>EMERGENCY RESPONSE</u>

(i) Emergency services to re-assess the model of hot and warm zones to consider whether they are realistic

81. Any recommendations in this area must be treated with great care as there is a potential to cause unwarranted public concern and for recommendations to be made which might in fact harm public safety if implemented. There is already considerable disquiet amongst emergency workers as a result of questioning in the inquests that those who do not risk their lives in emergency response will be criticised.

82. As the Chief Coroner is aware, the Joint Operating Principles (JOPs) for a MTA and the police PLATO guidance have already been reviewed since the 2017 attacks and revised guidance was issued in February 2019. As explained by Supt McKibbin, this has resulted in a reclassification of hot and warm zone definitions by way of a risk based approach (day 23 p19). Some of the matters raised in the families' submissions relate to greater flexibility in the model and have already been addressed in the amended guidance.

83. For the avoidance of doubt, it is not accepted that the model is (or was) *seriously flawed.*

(ii) Emergency services to consider whether the model wrongly assumes hot zones will be relatively confined and declassified as soon as a threat is neutralised

84. Over a number of paragraphs, a theory is developed that hot and warm zones are normally fairly closely defined geographical areas which can be swiftly declassified. It is recognised that due to the complex nature of the Borough Market attack this was not the case (for a number of reasons and as fully explored in the evidence).

85. Counsel for the families accept at [114] that in an attack of this nature a larger area may be classified as hot and may remain so for some time.

86. As counsel for the families recognise, the situation is complex. There is both a need (and legal obligation) to maximise the safety of unarmed responders who may come into contact with marauding terrorists and a need to treat casualties as soon as possible. This is something that is constantly addressed and re-evaluated by the emergency services at a national level, after attacks such as this and in table top and physical exercises. There has been considerable learning gleaned from the 2017 London and Manchester Arena attacks (see for example the Kerslake Report). Working practices can always be improved and this is ongoing.

87. The Chief Coroner will be aware that paragraphs 4.8 to 4.10 of the 2019 JOPs recognise the need to continuously review zoning, that the zones should be no larger than necessary and declassified as soon as possible. Equally the February 2019 PLATO guidance deals with agreeing Limits of Exploitation and the need to ensure that the boundaries of hot and warm zones are kept under continuous review and (when safe and practical to do so) consideration be given to rezoning to prioritise casualty management and the saving of life. It is wrong to assert as at [110] that the model does not recognise either that the public might be in a hot zone or that such an area might remain "hot" for several hours.

88. The hot zone was not "neutralised" when the terrorists were shot. There was no way to know that the explosive belts were not real until they had been examined by specialist officers. Equally it appeared that a terrorist in a red top was still at large with incoming reports from the public that terrorists were attacking with firearms. Secondary attacks are frequently utilised by terrorists to kill members of the emergency services. Hot zones cannot be declassified until those in charge of the operation are satisfied that it is appropriate to do so.

89. As to deployment of unarmed responders the position is necessarily different in hot and warm zones. The Chief Coroner will need to consider the current position. There is now greater flexibility as to how these zones are managed.

90. A hot zone is now defined as an area assessed to contain a credible and continuing threat to life, including the presence of attackers with weapons. The model recognises that this **may** result in the deployment of specialist and non-specialist responders depending upon the nature of the threat and attack methodology. The greatest care needs to be taken, however, in relation to unarmed personnel operating in such an area. It would be wrong to make any recommendation which undermined this principle. The updated guidance allows for an appropriate degree of flexibility.

91. A warm zone is now defined as an area where the attackers are not believed to be present at this time, but an identified threat remains. The 2019 JOPs recognizes that *response in the warm zone will vary depending on the attack methodology and the threat, and measures in place to mitigate that threat.* The updated guidance explicitly notes that *the availability of armed police officers to escort responders is not guaranteed and should not delay responder deployment.*

92. As set out above this is not an appropriate topic for a prevention of future deaths report and in particular in light of the 2019 guidance documents which already allow for a more flexible approach. A "radical change" as contended for at [117] is unjustified and in any event, significantly outside the scope of these inquests.

(iii) Emergency services to consider whether the model wrongly assumes emergency responders will not enter hot and warm zones and put in place plans to co-ordinate, support and communicate with workers in those zones

93. It is here suggested that as unarmed police officers went into the courtyard of Boro Bistro (in particular) to save lives, a policy which prevents unarmed workers from entering hot zones (in particular) is unworkable and so the model should recognise this and plan to assist workers in hot and warm zones.

94. In relation to hot zones these are the areas which present the greatest danger and where there is an ongoing threat to life from terrorist activity. Moving towards an assumption that unarmed responders will work in hot zones is simply wrong. Unarmed responders may be deployed into a hot zone but this will be a decision based upon an assessment of the nature of the attack and the weaponry believed to be possessed by the terrorist. The Chief Coroner will note the flexibility afforded in the 2019 guidance as summarised above.

95. In relation to warm zones as set out above, the 2019 JOPs document recognises that availability of armed police officers to escort responders should not delay responder deployment. Plans are in place to co-ordinate, support and communicate with all responders including unarmed workers who enter warm zones. This is not an appropriate topic for a prevention of future deaths report and especially so in light of the 2019 guidance which already allows for a more flexible approach.

(iv) Plans should be put in place for emergency medical assistance to be provided to casualties in hot and warm zones at the earliest possible time

96. The observations set out above are repeated. Such plans are already in place. An examination of the casualty evacuation schedule confirms that casualties in the hot zone were swiftly evacuated. Those who remained in the hot zone had tragically died. There is no need for a recommendation such as this to be made.

97. Counsel for the families recognise that it is a trite observation that time is of the essence when treating catastrophic injuries. The police (and LAS) are very much aware of this.

(v) Plans should be made for the extraction of casualties in hot and warm zones to cold zones and then to hospital

98. As set out above such plans exist and casualties were swiftly evacuated during the attack. There is no need for a recommendation such as this to be made.

(vi) LAS to put procedures in place to ensure specialist teams with training of working in warm zones are rapidly deployed

99. This does not relate to the MPS but please see the above.

(vii) Designated person to have responsibility to ascertain the location of casualties

100. It is unclear whether this is proposed to be a police or LAS resource.

101. It is submitted that such a proposal is well intentioned but is an example of a prescriptive recommendation specific to the facts of these events. There is no basis for saying that this would have altered the outcome on the night (the Coroner found that it would not) and there are reasons to believe that in a different set of circumstances such a designated resource could divert staff from other life-saving duties.

102. That is not to say that the police did not and will not learn and adapt working practices based upon this attack but such a prescriptive recommendation would not save lives.

(viii) HMG to reconsider run, hide and tell

103. This paragraph is directed at HMG but the responsibility for the "run, hide, tell" (RHT) guidance lies with the police. Neither the evidence nor any of the matters raised by the families justify changing RHT.

104. The basis of the families' position is that if there are likely to be long delays in emergency medical treatment reaching those in danger zones then casualties should be advised to make their own way to a place where they can obtain assistance. As set out above no lives were lost or risked by a delay in medical treatment. Casualties were swiftly evacuated. The premise is therefore misplaced.

105. In any event the full public informational message behind RHT is:

Run until you are clear of the threat

Hide if you are unable to run and stay hidden until the emergency services arrive

Tell when it is safe to do so

106. It is already the case therefore that those who can run are advised to do so. RHT is frequently reviewed and evaluated and this will continue.

(ix) Additional medical equipment and training to be made available to the police who will provide medical assistance in warm and hot zones

107. Firearms officers already have extremely high levels of training in emergency first aid. Training is constantly evaluated and improved upon. Equipment is also regularly reviewed. The MPS is assisted by national guidance as provided within Module D13 of the National Police Firearms Training Curriculum (NPFTC). This module details the clinical techniques and tactical considerations for use by armed

officers. It also provides guidance in respect of the local clinical governance arrangements that should be in place to support the delivery of this training.

108. It is not accepted that there is a systemic failure or risk identified in the medical training and or equipment provided to officers and there was certainly no evidence of such. A general observation that there is always room for improvement does not justify a recommendation from the Chief Coroner.

(x) Police to consider if radio talk-groups are being used in the most effective way especially in communicating with ARVs

109. Counsel for the families identify that PC Duggan did not hear a radio transmission that was broadcast on a channel he was listening to. PC Duggan was questioned on the basis that it was *obvious* that there was a terrorist attack (Day 4 p117) which he should have responded to, not that there was a failure in the equipment or use of radio talk groups.

110. The evidence was that PC Duggan's radio was tuned to a channel which did transmit the relevant information but that he did not hear this. This is not a failure by PC Duggan or by the *way radio talk groups are used.*

111. PC Duggan humanely and bravely treated Christine Archibald on the bridge when he saw her terrible injuries. In different circumstances he might have saved her life. The evidence in fact established that he could not have saved lives by pushing forward into the market.

112. If all three channels were merged into one this would in fact increase the risk of messages being missed.

113. There is no need for a recommendation of the kind proposed.

(xi) Police forces and other emergency services should explore technical means to ensure incident commanders can communicate effectively with responders on the ground

114. Communication is always going to be difficult in an incident such as this. Counsel for the families appear to be suggesting that rather than or in addition to radios a "*text-based communication system*" be introduced. Whilst this might be an interesting idea that is not the test for inclusion in a report to prevent future deaths.

115. The police and emergency services constantly explore means of improving communications. Police vehicles are already fitted with mobile data terminals which enable officers to access data from the CAD system in a manner similar to that suggested.

(xii) Review of the emergency button

116. It is said to be a concern that the emergency button produced white noise as so many officers were pressing it. This is unsurprising. The emergency button will send

a transmission to the "top of the queue" when pressed. If multiple officers push it at the same time, by definition they will not all be able to transmit. The emergency button (as counsel for the family note) works well and is a valuable police tool. It regularly saves lives.

117. In a MTA officers are not reliant on conventional officer safety equipment. Elaborate plans such as Operation PLATO exist to produce a far greater response than the emergency button. That is why as acknowledged at [151], assistance came very rapidly.

118. There is no basis for a report to make recommendations in this area.

(xiii) Technical measures to enable location of people and vehicles

119. The families concern relates to the locating of LAS officers.

120. It was accepted in evidence that this is being explored by the LAS and MPS. There are significant technical obstacles which must be overcome before this becomes a practical reality. These obstacles are being addressed.

121. Evidence was heard about the ability of the MPS to locate its own officers. A more sophisticated scheme already exists in relation to CTSFOs. Work continues in this area. As detailed multi agency work is already well underway a recommendation is not required.

(xiv) Co-location of control rooms

122. It is submitted that co-location is overly prescriptive and unlikely to be practical or effective. The evidence was that in London, given the size of the emergency services, co-location would represent a significant challenge (Day 23 p 69). Counsel for the families appeared to recognise this and suggested instead the embedding of "one or two" staff members from LAS or LFB in the control room (Day 23 p 70).

(xv) Merger of COLP and MPS

123. A report to prevent future deaths is not a suitable procedure to pursue this idea. First, the test is manifestly not made out and second, there was a complete absence of evidence that such a momentous change would be desirable let alone effective in preventing future deaths. In any event as the attack unfolded, the evidence demonstrated that the quality of the interoperability between the COLP and the MPS was of a very high order.

124. The Metropolitan Police Service would like to pass on sincere condolences to the families of those who died in the attacks. The MPS will continue to do all it can to prevent attacks in the future.

06 September 2019
Richard Horwell QC
Matthew Butt
Three Raymond Buildings
Gray's Inn
London